Indiana J-1 Visa Waiver Program

The Indiana State Department of Health
in Collaboration with
The Indiana Primary Health Care Association

Application

Personal Information

Name of Applicant: _____
First Middle Last

Country of Origin _____ Area of Expertise _____

DOB: _____ Please circle one: MD DO

Address of Applicant: _____
Street

_____
City State Zip Code

Phone Number: _____ Fax Number: _____

Email: _____ Pager Number (optional)_____

Case Review Number:_____ Indiana Medical License Number_____

Attorney Information

Attorney/Firm Representing the Applicant: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____

Email: _____

Facility Information

Employer: _____

Employer's Contact Person _____

Address: (Include the County): _____
Street

_____
City County State Zip

Phone: _____ Fax: _____

Email: _____

Practice Site Address (if different)

_____
Street City County State Zip

Phone: _____ Fax: _____ Email: _____

HPSA ID #_____ MUA/MUP ID# _____

Census Tract # _____ FIPS County Code _____

Type of Facility: ☐ Hospital ☐ Safety Net Provider

☐ Federally Qualified Health Center/Look Alike _____

☐ State funded Community Health Center _____

☐ Rural Health Clinic (not for profit) _____

☐ Rural Health Clinic (for profit) _____

☐ Other _____

☐ Indiana State Department of Health Funded Facility

If multiple sites, give all information for each site on attached separate sheet.